Maine Breast and Cervical Health Program
Initial Enrollment Form

Office Use Only: Screening Day _____

***Enrollment Backdated*: __ __ /__ __ / __ __**

Note: Please put an answer on each line or this form may be returned to you.

Please Print:

Name (First, MI, Last): _____Phone: (_ _ _) __ __ __ - __ __ __ __
(Home)

Home Mailing Address: _____

City: _____ State: _____ Zip: __ __ __ __ __

Date of Birth: __ __ / __ __ /__ __ __ __ Social Security: __ __ __ - __ __ - __ __ __ __
Month / Day / Year

Contact Person in case we can't reach you: _____ Phone: (_ _ _) __ __ __ - __ __ __ __

May we contact you at work? _____ Yes _____ No Phone: (_ _ _) __ __ __ - __ __ __ __

Please check a space for each question below:

Are you Spanish, Hispanic or Latina? _____Yes _____No

Are you: _____ White; _____ African American; _____ Asian; ____ Native Hawaiian/Other Pacific Islander

_____ American Indian/Alaskan Native; _____ Other: Specify _____

Income: **Note: If you farm or are self -employed, Use net taxable income: Include 1040 Tax form**

Income before taxes (for you, your spouse and children under 21 yrs of age who are not students):$ _____ /yr

Number of people (including yourself) who are supported by this income _____

Health Care Coverage:

Do you have Medicare Part A? _____Yes _____No

Do you have Medicare Part B? _____Yes _____No **(If yes, you are not eligible for MBCHP)**

Do you have MaineCare (Medicaid)? _____Yes _____No **(If yes, you are not eligible for MBCHP)**

Do you have any health insurance? _____Yes _____No

If yes, does your health insurance have a small deductible or co-payment? _____Yes _____No
(If yes, you may not be eligible for MBCHP)

Name of Insurance Company: _____

Insurance Company Phone Number: (_ _ _) _ _ _ - _ _ _ _ Insurance Deductible $_____

Name of policy holder: _____ Date of Birth policy holder: __ __/__ __/__ __ __ __

Policy Holder's Social Security #: __ __ __ - __ __ - __ __ __ __

Policy #: _____ Group #: _____

Is Insurance through your (or your spouse's/partner's) employer? _____Yes _____No
If yes, Name and City of employer: _____

Signature: _____ Today's Date: __ __ / __ __ /__ __ __ __

(Go To Next Page and Complete)

Office Use Only:
Site Name: _____ Site Number:_____

Maine Breast and Cervical Health Program Consent

(Initial Enrollment Form Continued)

Health Information Questions:

Before joining this program, had you ever had a Mammogram? _____Yes _____No
If yes, date last done: __ __ / __ __ /__ __ __ __ If more than 5 years ago, check here _____

Before joining this program, had you ever had a Pap test? _____Yes _____No
If yes, date last done: __ __ / __ __ /__ __ __ __ If more than 5 years ago, check here _____

Have you had a hysterectomy? _____Yes _____No _____Don't know
If yes, was it for cervical cancer? _____Yes _____No _____Don't know
Do you still have any part of your cervix remaining? ____Yes _____No _____Don't know
Date of hysterectomy: __ __/__ __/__ __ __ __

Do you need any special assistance (such as a translator)? _____Yes _____No
If yes, please explain: _____

Do you have any medical bills from appointments for breast/cervical screenings in the last 90 days?
_____ Yes _____ No If so, from where? _____
Date of screening: __ __/__ __/__ __ __ __

How did you hear about the Maine Breast and Cervical Health Program? _____Brochure (from where? _____);
_____Doctor/Nurse; _____Family/Friend; _____Mammography Site; _____CAP; _____Coalition; ____Television;
_____Newspaper; _____Hospital; _____Radio; _____Tribe; _____Other (list_____)

Consent Statement:

By signing the Consent Statement below I agree to let the Maine Breast and Cervical Health Program:

- Collect information about me and my breast and cervical cancer screenings, diagnosis and treatment, if necessary;
- Contact me to ask questions to help improve the Program and contact me to offer assistance in obtaining services;
- Contact my doctors for my screening and test results and contact me with my screening and test results.

All information about me and my screenings and tests is kept private and completely confidential. Please read the Consent Statement below and sign your name with today's date. If you have any questions about the consent please call 1-800-350-5180, TTY (Deaf or Hard of Hearing) 1-800-438-5514.

The Maine Breast and Cervical Health Program (the Program) collects information from all participants in order to receive funding from the federal government. Any information turned over to the Program will be treated confidentially in accordance with the provisions of 22 M.R.S.A. §1711-C, which means the information will be used to meet the purposes of the Program and any published reports which result from this Program will not identify me by name. By agreeing to take part in the Maine Breast and Cervical Health Program, I understand that I may be contacted to provide information to evaluate the Program and may be offered case management services. In addition, I give my permission for all of my health care providers, clinics, hospitals, mammography facilities, labs, and/or health insurance providers to provide all information concerning my Pap smears, breast exams, mammograms, radiological or laboratory results and/or care and treatment related to the Program. Such information may include services covered by the Program and delivered up to three months prior to the date of my signature on this form. I understand that once I have had a Maine Breast and Cervical Health visit, the Program will be allowed to obtain medical information for all breast and/or cervical procedures, cancer screenings, diagnosis and treatment. I understand that I have a right to request a copy of my Program records pursuant to 22 M.R.S.A. §1711-B and may request that amendments be made to any incorrect or incomplete information contained in my records if my request is submitted in writing. I understand that notifying me of test results is a very important purpose of this Program, and that all available resources may be used to notify me if I have an abnormal test result.

I understand that my participation in this Program is voluntary and that I may drop out of the Program and withdraw my consent at any time.

Signature: _____ Today's Date: __ __ / __ __ /__ __ __ __

Return Form to: MBCHP, 11 State House Station, Augusta, ME 04333 or Fax to: (800) 325-5760